MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Main Rehab & Diagnostic 3710 Rawlins, Ste. 1400 Dallas, TX 75219	MDR Tracking No.: M4-04-1254-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Sentry Insurance Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.: 51C259083

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
11/07/02	**11/08/02**	**97545-WH-AP & 97546-WH-AP**	**$128.00**	

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 9/23/03 states in part, "…These services were not paid according to the TWCC Fee Guideline…Per TWCC Fee Guideline, the MAR for the Work Hardening allows $64.00 an hour if Carf Acredited…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 10/17/03 states in part, "…The carrier asserts that it has paid according to applicable fee guidelines…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Requestor's representative was contacted and reveal that the insurance carrier made an additional payment of $76.80 for date of service 11/08/02, leaving a balance of $128.00 due.

- CPT Code 97545-WH-AP for dates of service 11/07/02 and 11/08/02. Payment Exception Code is "F". Per the 1996 Medical Fee Guideline, Medicine Ground Rule (II)(C) and (E)(5) CARF Accredited facilities are reimbursed $64.00 per hour. The requestor billed $128.00 ($64.00 x 2) per day for the first hour; the insurance carrier reimbursed $102.40 ($51.20 x 2) per day leaving a balance of $25.60 per day. Additional reimbursement of $51.20 ($25.60 x 2) is recommended.

- CPT Code 97546-WH-AP for date of service 11/07/02. Payment Exception Code is "F". Per the 1996 Medical Fee Guideline, Medicine Ground Rule (II)(C) and (E)(5) CARF Accredited facilities are reimbursed $64.00 per hour. The requestor billed $384.00 ($64.00 x 6); the insurance carrier reimbursed $307.20 ($51.20 x 6) leaving a balance of $76.80. Additional reimbursement of $76.80 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
11/7/2002	97545	$25.60	$25.60				
11/08/03	97545	$25.60	$25.60				
11/7/2002	97546	$76.80	$76.80				
				Total Left Column:			$128.00
				Total Amount Due:			$128.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $128.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	01-28-05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____